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EDITORIAL

In this issue...

Besides issue three being our conference season issue, we are also publishing three pertinent papers, all of which are likely to have a lasting impact on research and acute care in Africa for the next few years. The first is the proposal for a dedicated reporting checklist for resource tiered reviews (editorial). This checklist will allow AfJEM to publish reviews which will either provide best practice evidence on every level of resource availability or highlight the absence thereof, allowing opportunities for further research. To tie in with this the findings from the African Federation for Emergency Medicine's (AFEM's) Consensus Conference held in Cape Town, South Africa in 2013 as well as those of the Emergency Medicine conference held in Gaborone, Botswana in 2014 can also be found in this issue (other matters of interest). The former takes a continent wide perspective, whereas the latter sets the agenda for the Southern African region. Policy makers, researchers and prospective authors should have no problem finding a wealth of information and original research packed into our biggest issue yet.

Acute management of ST-elevation myocardial infarction in a tertiary hospital in Kenya: are we complying with practice guidelines?

Wachira et al. use a retrospective cohort to describe the current standard of care provided for patients presenting with STEMI to a large tertiary emergency centre (EC) in Nairobi. Lack of a public prehospital system, use of thrombolysis and low compliance with international door-to-needle and balloon benchmarks suggest a reasonable resource setting which still has some way to go to reach an international standard. The authors appropriately identify this in their discussion, also highlighting the importance of primary prevention programmes. It would be interesting to see some further local research with regard to the rising problem of acute coronary syndrome.

Epidemiology of patients presenting to the emergency centre of Princess Marina Hospital in Gaborone, Botswana

Chandra et al. describe a cross-section of patients that attended to their EC between 2010 and 2011. Communicable diseases were the commonest presentation, trauma second, pregnancy related presentations third and non-communicable diseases fourth. For 31% of patients this referral centre was their first point of access into the healthcare system. The authors comment on the appropriateness of self-referred attendance, including the high discharge rate (83%) of those triaged green though it should be kept in mind that only 15% were triaged green. Managing this sample is important (e.g., streaming, diverting, etc.) whilst bearing in mind the benefits are often disappointing.

Epidemiology of injuries, outcomes, and hospital resource utilisation at a tertiary teaching hospital in Lusaka, Zambia

Seidenberg et al. present data from a pilot study used to develop a trauma registry in Zambia. The obvious differences compared to the demographics seen in high income countries are the high self-presentation rate (only 5.8% of patients arrived by ambulance) and also the high rates of road traffic collision (25%) and interpersonal violence (20%) related injury. Falls accounted for the highest proportion of injury presentations (26%). About half of patients were admitted for further care. Seeing which injury groups were admitted or died as well as injury severity scores are not presented, however this information will likely be more reliable once the registry is set up and the sample size has grown.

The sick lady who cried wolf: a case of Wellens' syndrome presenting in the shadow of chronic sickle cell pain

Gede et al. describe this fascinating case of a young Zimbabwean lady who presented with a Wellens' syndrome, an ECG finding associated with a high risk of imminent anterior myocardial infarction. Despite being in a setting where cardiac catheterisation was not available, authors used the messaging capability of a cell phone to confirm the diagnosis with a cardiologist in the USA before sending this woman to the nearest cardiac catheterisation centre, 300 km away and essentially saving her from becoming a cardiac cripple.

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Emergency pericardiocentesis under dynamic ultrasound guidance in the resource limited setting

Following on from innovative solutions within resource restricted settings, Loughborough presents a case of a critically ill HIV patient with a suspected pericardial tamponade. Using ultrasound and a simple central venous catheter, pericardiocentesis was performed resulting in stabilisation of the patient's clinical findings.

ECG lead misplacement: a brief review of limb lead misplacement

Purposefully placed towards the end of the case report section and just before the review section, Lynch discusses ECG lead placement errors around a case study resulting in an in depth review of the topic. There is no easy way to detect these errors unless you are actively looking for it and with the exception of the more obvious ECG abnormalities (e.g., positive R-waves in lead aVR or an extreme axis). This goes to show the further value of repeat ECGs which should in any case be standard of practice for all chest pain presentations.

The diagnosis of and emergent care for the patient with subarachnoid haemorrhage in resource-limited settings

Modisett et al. present a detailed review of subarachnoid haemorrhage (SAH) care within low to middle income countries. Despite risk factors being mainly based on research from high income countries, history and exam should really differ very little irrespective of setting. The main problem with regard to SAH in acute care is being effective gatekeepers when patients present with very little symptoms. The authors helpfully provide algorithms for the diagnostic approach in both a well- and under-resourced setting. I would add that where symptoms are severe and access to neurosurgical centres or stroke services is limited, active palliation can also be considered as an appropriate care option.

Conflict of interest

None.

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